COMMONWEALTH OMBUDSMAN

Private Health Insurance Ombudsman How we deal with complaints (Information for insurers)

In our role as the Private Health Insurance Ombudsman (PHIO), the Office of the Commonwealth Ombudsman (the Office) receives and responds to complaints about private health insurers and other enquiries about the private health insurance system.

The Office can deal with complaints about any private health insurance arrangement, including complaints from and about healthcare providers, brokers and hospitals. This document focuses on the process of handling complaints made about private health insurers.

This fact sheet provides the following information for insurers about engaging with our Office:

- how we respond to contacts
- how we categorise our contacts and what this means for insurers
- what insurers can expect in their engagement with us
- what we expect from insurers in return.

Categorising our contacts and how we respond

The Office receives contacts ranging from simple enquiries to matters that do not require investigation and can be referred to the service provider, through to matters requiring mediation or a formal recommendation under the *Ombudsman Act 1976*.

To facilitate our data collection and provide greater transparency in our reporting we categorise the contacts we receive based on the following factors:

- type of contact
- degree of Office involvement required to resolve the matter
- any potential sensitivity.

The categorisation of the contact reflects the action taken by our Office and does not reflect the outcome of the enquiry or complaint (that is, whether or not the insurer was at fault).

Contact us

ombudsman.gov.au
1300 362 072

GPO Box 442
Canberra ACT 2601

The following table outlines the categories used by the Office in relation to private health insurance contacts:

Category	Description *Enquiries do not count as complaints in the Office's reports*
Enquiry	The matter does not constitute a complaint. It might be a general enquiry about the private health insurance system, or to the extent it raises a problem, it is not one that is within our jurisdiction to consider (for example, a complaint about the quality of health care). **Enquiries** can be resolved by the provision of general advice or information.

Complaint category	Description *All complaint categories are counted as complaints in the Office's reports*
No further action taken	The person has made a complaint to us about their insurer, taken steps to resolve the matter with their insurer, but remains unhappy. After assessing the complaint, we have determined that further engagement with the insurer or investigation of the complaint is not taken. These complaints will generally be finalised by our Office providing the person with an explanation or information regarding their complaint and an explanation as to why we have decided not to investigate.
Standard referral	The person has made a complaint to our Office about their insurer, but the insurer has not yet had adequate opportunity to resolve the matter. The Office provides the person with information to assist them to approach their insurer directly.
Assisted referral	The person has made a complaint to our Office about their insurer and the Office assists by referring the matter to the person's insurer on their behalf. We request an email response from the insurer advising us when the complainant has been contacted.
Investigation	The person has made a complaint to our Office about their insurer and has been unable to resolve the matter with their insurer. After assessing the matter we have identified issues which require further information from the insurer. For investigations we will request a report and information from the insurer and assess the case. We will seek to mediate the disputed matter between the parties or investigate the matter further. For complex investigations there may be numerous contacts with the insurer and the complainant.

No further action taken

Where we receive a complaint and consider that there is no need to contact or seek additional information from the insurer, we finalise these complaints by providing more information or a clearer explanation directly to the complainant. These are included as complaints in our reporting but insurers will not hear from us in relation to these matters. Insurers may contact the Office on an ad hoc basis for more information on their complaints in this category.

Referrals to insurers

We consider that insurers are best placed to attempt to resolve problems in the first instance and should be given adequate opportunity to do so. Direct engagement with an insurer will often enable the complaint to be resolved in the quickest way possible. Where this does not resolve the complaint, people are encouraged to return to our Office to ask us to consider the complaint.

We have two processes to refer complaints to insurers: *standard referrals* and *assisted referrals*.

Complaints which require further consideration are categorised as *investigations*.

Standard referrals

Where the person has not raised their concerns with their insurer directly, we will generally make a *standard referral*. We will provide advice to the person about approaching their insurer and contact details for the recommended or preferred approach method.

Assisted referrals

Where the person *has* raised their concerns with the insurer but we do not think the insurer has had an adequate opportunity to deal with it, we make an *assisted referral*.

We might consider that the insurer has had an *adequate opportunity* to deal with a complaint if:

- The complainant has spoken to staff at the call centre/branch about the problem, it was not escalated and they believe it remains unresolved.
- The complainant has written to the insurer and has not received a response or been contacted by the person (even if an interim response) within 21 days.
- The complainant has had an email response from the insurer but considers the matter still unresolved.
- The complainant has been in contact with the customer resolutions or the member relations area of the insurer and considers the matter still unresolved.
- The complainant has spoken to insurer staff at the branch or call centre but due to the urgency or complexity of the matter, considers assistance from the Office is required.

We might also make an assisted referral if a complainant requests that we deal with their matter due to the nature of their concerns or a perceived breakdown in their relationship with the insurer.

In some cases we may consider it appropriate to refer a complaint as an assisted referral even if the person has not yet contacted the insurer—for example:

- if they have an upcoming hospital admission
- the matter is high risk or high value
- the person requires special assistance
- the person is not confident in their ability to articulate their concerns to their insurer.

For an assisted referral, we will email the insurer with the complainant's name, membership number (if provided), a brief summary and any special circumstances. We will request that initial contact is made with the complainant by the insurer within three business days (or less if urgent), not including the day the complaint was sent.

An *urgent* matter is where a person requires a quick response, for example in cases of impending hospital admission or if the person is suffering immediate financial hardship.

We ask that insurers provide an email response advising us of when the complainant has been contacted and the complainant's response. An email summary of the insurer's response explaining what resolution has been reached and what contact has been made with the person is generally sufficient. Call recordings, policy documents and detailed information are not required at the assisted referral level.

Complaint – investigation

If we consider that the insurer has already had an adequate opportunity to deal with a complaint, we will assess whether the case requires further consideration. If there are issues that merit investigation, we will characterise the complaint as an investigation, contact the insurer with details of the case and ask the insurer to provide all details relevant to the complaint to us within 14 days.

The following are examples of situations where we might categorise a complaint as an investigation:

- the matter is particularly complex or may involve systemic failure
- our direct involvement is required due to the urgency of the matter
- the matter is about the outcome of a Pre-existing Condition decision by the insurer
- the person is unable to deal with the matter themselves due to disability, illness, hospitalisation or level of distress
- the matter has been referred to us by a member of Parliament, state/territory healthcare complaints, fair trading bodies or other organisation
- we are unable to provide an explanation to the complainant without further information from the insurer
- we need the insurer's viewpoint to judge merits of the complaint. In some straightforward matters such requests may be dealt with by telephone to the insurer contact, rather than requiring a report.

Contact between the Office, insurer and complainant

We request that insurers do not contact the complainant directly in relation to investigations. We will review the insurer's response and provide our response directly to the complainant. Often, the complainant has asked for our help because they do not want to deal with the insurer.

We will notify both the insurer and the complainant of the outcome of the investigation and confirm the matter is closed in writing (by email, unless this is not an option).

Complainants have the right to request an internal review of our handling of their complaint. This can sometimes lead to an investigation being reopened and the insurer contacted again for further information.

For more information about what complainants can expect from the Office and the Office's expectations of complainants, please see our Service Charter.

Reports from the insurer

While our request for a report from an insurer will specify what we are seeking, in general we are seeking details relevant to the complaint. This may include screen shots from customer records, membership application records, correspondence and call recordings. Complaints often involve allegations of misinformation and the provision of call recordings and other records that assists the Office to make an impartial and evidence-based assessment of the case.

A report from an insurer should also include the insurer's response to the complaint, the proposed resolution and reasons behind its decision. When an insurer is referring to specific documentation in its response, such as call recordings, rules, letters, etc. they should be provided at the same time, along with any other documentation that we have requested.

Responses to investigations, including all requested and/or referenced documentation are due within 14 days of the complaint being sent to the health insurer. If documentation is not provided with the initial response the insurer has 24 hours to provide this upon our further request. We will review the insurer response and documentation within seven days of receipt and advise if further information is required.

When we have reviewed the complaint and require further information, the insurer has a follow up period of seven days for further review and to provide us with an additional response.

Sharing information with the complainant

The Office may share some information from the insurer's report with the complainant where that information is directly addressed to the complainant or relates to the complainant's contacts with the insurer. For example, copies of emails, letters and brochures previously sent to the complainant.

The Office will not share copies of call recordings with the complainant except where the insurer has agreed to its release. In the first instance, the Office will refer the complainant back to the insurer to request copies of call recordings.

The Office will not share information with the complainant that is not directly addressed to them, such as internal insurer correspondence or correspondence between the insurer and a third party, except in cases where the insurer and any other parties have agreed to its release. A complainant may request documents under the *Freedom of Information Act 1982* (the FOI Act), although if subject to an exemption under the FOI Act, we may refuse to provide these documents.[1]

General complaint handling arrangements

Complaint contact arrangements

Insurers should keep us updated with any change in contact arrangements by emailing us at phi@ombudsman.gov.au. We request at least one email address and one direct phone number (not a 1300 queue number) on which we can make direct contact with the insurer.

It is preferable for insurers to provide us with a single shared email address as their point of contact for complaint handling rather than an individual's email address or multiple individual email addresses. This avoids the problem of missed emails if a person is absent or moves on from the organisation.

Insurers may, but are not required to, inform us of special instructions for specific circumstances (such as for urgent cases or for overseas visitor/overseas student cases).

Queries regarding complaint categorisation

We undertake quality assurance prior to public reporting, including assessing each case for accuracy in categorisation. If an insurer considers that a complaint has been incorrectly categorised, the insurer can contact us via phi@ombudsman.gov.au. We will consider the same factors as outlined above when determining whether a complaint categorisation is correct, including the description of the complaint provided by the complainant at first instance and the amount of work undertaken by our Office in dealing with it.

[1] Further information about how the Office deals with freedom of Information requests can be found here: Freedom of Information - Commonwealth Ombudsman

Public reporting

We use the complaint categorisation system outlined in this fact sheet to assist with our public reporting. Our Quarterly Bulletins, Annual Report and the State of the Health Funds report will usually contain information about the number of enquiries and complaints we receive, as well as the action taken to resolve those matters.

More information is available at **ombudsman.gov.au**.

Please note: This document is intended as a guide only. For this reason, the information should not be relied on as legal advice or regarded as a substitute for legal advice in individual cases. To the maximum extent permitted by the law, the Commonwealth Ombudsman is not liable to you for any loss or damage suffered as a result of reliance on this document. For the most up-to-date versions of cited Acts, please refer to the Federal Register of Legislation.

Approach from consumer to the Ombudsman

Enquiry: we respond to the consumer and close the case.

Complaint: we assess the person's complaint issue, possible resolutions, the consumer's contact with the insurer and whether the insurer has had an adequate opportunity to respond to the person.

In some cases we may approach the insurer for more information about a consumer's Enquiry. However, these do not count towards complaint statistics.

No further action taken

An explanation is provided to the person. No further action is taken and the case is closed.

Standard referral

The person has not raised their concerns with their insurer directly. We provide advice to the person about approaching their insurer and record the complaint.

If the issue remains unresolved following a Standard Referral, the person may approach the Office again for further assistance. We may choose to close the complaint with a further explanation or the complaint may be escalated to an Investigation.

Assisted referral

The person has raised their concerns with the insurer but the insurer has not had an adequate opportunity to deal with the matter. We refer the matter to the insurer for response.

The insurer's response to our Assisted Referral should include feedback on how they have dealt with the complaint.

If the issue remains unresolved following an Assisted Referral, the person may approach the Office again for further assistance. We may choose to close the complaint with a further explanation or the complaint may be escalated to an Investigation.

Investigation

If the insurer has had an adequate opportunity to deal with a complaint and the issue still merits investigation, we will begin an Investigation and ask the insurer for a report. We will notify both the insurer and the complainant of the outcome of the case and confirm the matter is closed in writing.

If the person is dissatisfied with an Investigation, they have the right to request a review from the Office.